

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026400

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6036

STATE FILE NUMBER

FILED JUN 21 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in lb

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Mo.

b. COUNTY

Inside Limits

Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION Homer Phillips Hosp.Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

5446 Wells Ave.

Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Clara

Louise

Smith

4. DATE
OF
DEATH

Month

Day

Year

June 6, 1963

5. SEX

Female

6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

10-19-19

9. AGE (last birthday)

43

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
nurse's aide10b. KIND OF BUSINESS OR INDUSTRY
Hospital11. BIRTHPLACE (City and state or country)
Little Rock, Ark.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Calhoun Cunnigan

13b. MOTHER'S MAIDEN NAME

Hattie Barber

14. NAME OF HUSBAND OR WIFE

Leon Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Clarence Hamiel, 5446 Wells Ave.

18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarct:

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Pericardial Effusion

DUE TO (c)

434.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

to

and last saw her
him alive on

Death occurred at

755 A

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Degree or title

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

23b. DATE

6-10-63

23c. NAME OF CEMETERY OR CREMATORY

Washington Park

23d. LOCATION (City, town, or county)

Berkeley City, Mo.

24. FUNERAL DIRECTOR

ADDRESS

A.D. Richardson, 2625 Glasgow Ave.

25. DATE RECD. BY LOCAL REG.

JUN 8 1963

26. REGISTRAR'S SIGNATURE

D. Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Andrew D. Richardson, Jr.

Licensed Embalmer No.

4858

P. O. Address

2625 Glasgow Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.